IDENTIFYING NAME OF PLAN: _____

Form HC-7(a-2)
(Rev. 01/08)

"SERVICE" TYPE PLANS

BENEFITS	KPGP MEMBER PAYS	EXPLAIN ANY VARIATION FROM KPGP
OFFICE VISITS	$15.00 per visit	
OUTPATIENT SURGERY AND PROCEDURES	$15.00 per visit	
HOSPITALIZATION		
365 days per year	$50 per day	
SKILLED NURSING CARE		
Up to 60 days of skilled nursing care per Benefit Period	No charge	
OBSTETRICAL (MATERNITY) CARE		
Routine: Prenatal, delivery, and postpartum visit	No charge	
INTERRUPTED PREGNANCY		
Elective abortion	$15.00 per visit. Limited to 2 per lifetime.	
Medically indicated abortion	$15.00 per visit. No limit on medically necessary abortions.	
IN VITRO FERTILIZATION	20% of applicable charges. One-time only under Kaiser Permanente.	
LABORATORY, IMAGING, and TESTING		
Inpatient	10% of applicable charges	
Outpatient	10% of applicable charges	

Form HC-7(a-2)
(Rev. 01/08)

"SERVICE" TYPE PLANS

BENEFITS	KPGP MEMBER PAYS	EXPLAIN ANY VARIATION FROM KPGP
PHYSICAL, OCCUPATIONAL, SPEECH THERAPY	Limited by significant, measurable improvement, KP clinical guidelines apply. Inpatient: no charge Outpatient: $15.00 per visit	
PHYSICAL EXAMINATIONS Medically indicated physical examinations	$15.00 per visit	
EMERGENCY COVERAGE Within Hawaii service area Outside Hawaii service area	$50 per visit, plus other applicable plan charges 20% of applicable charges, plus other applicable plan charges	
EMERGENCY AMBULANCE -- AIR & GROUND	20% of applicable charges	
HOSPICE SERVICES (Two 90-day periods, followed by an unlimited number of 60-day periods. The member must be certified by a Physician as terminally ill at the beginning of each period.)	No charge	

"SERVICE" TYPE PLANS

BENEFITS	KPGP MEMBER PAYS	EXPLAIN ANY VARIATION FROM KPGP
MENTAL HEALTH SERVICES AND CHEMICAL DEPENDENCY SERVICES		
Mental Health (non serious mental illness) -- Outpatient	20% of applicable charges. Up to 24 visits per calendar year	
Mental Health (non serious mental illness) -- Inpatient	20% of applicable charges. Up to 30 days per calendar year	
Chemical dependency – residential	20% of applicable charges. Up to 60 days per calendar year. 2 treatment episode limit.	
"Serious Mental Illnesses" (= schizophrenia, schizo-affective disorder, bipolar types I & II, major depression, dissociative disorder, obsessive compulsive disorder, and delusional disorder)	Outpatient: unlimited visits at $15.00 per visit Inpatient: unlimited days at $50.00 per day	
and		
Chemical dependency services (outpatient and inpatient)		
OUT-OF-POCKET LIMITS		
Individual	$2,000 per calendar year	
Family (3 or more individuals)	$6,000 per calendar year	

"SERVICE" TYPE PLANS

BENEFITS	KPGP MEMBER PAYS	EXPLAIN ANY VARIATION FROM KPGP
EXCLUSIONS No benefits will be paid in connection with: alternative medical services (e.g. – acupuncture, chiropractic etc…), artificial aids (e.g. - eyeglasses, contact lens, hearing aids etc…), cardiac rehabilitation, corrective appliances (e.g. - orthotics, braces, external prosthetics, splints etc…), cosmetic services, dental care services, services and related paperwork required by an outside agency/body, take home drugs, non-FDA approved drugs and devices, custodial and intermediate level nursing facility services, durable medical equipment, employer or government responsibility, experimental or investigational services, homemaker services, radial keratotomy or similar procedures, long term or maintenance therapies (physical, occupational and speech), take home supplies, travel immunizations, routine foot care, sexual dysfunction, transportation (except for medically necessary ambulance services), lodging, living expenses, gender reassignment, reversal of voluntary infertility, services and supplies not medically necessary.		